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10/92 2. In addition, to be deemed a DSH hospital, a hospital must provide the Department, in writing, with the names of at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid Plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This requirement does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age; or does not offer nonemergency obstetric services as of December 22, 1987. Hospitals that do not offer nonemergency obstetrics to the general public, with the exception of those hospitals described in Sections C.1. through C.4. of Chapter II., must submit a statement to that effect.

10/92 3. In making the determination described in Sections C.1.a. and C.1.d. of this Chapter, the Department shall utilize:

10/92 a. The hospital's final audited cost report for the hospital's base fiscal year. Medicaid inpatient utilization rates, as defined in Section C.8.e. of this Chapter, which have been derived from final audited cost reports, are not subject to the Review Procedure described in Chapter IX., with the exception of errors in calculation.

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b. In the absence of a final audited cost report for the hospital's base fiscal year, the Department shall utilize the hospital's unaudited cost report for the hospital's base fiscal year. Due to the unaudited nature of this information, hospitals shall have the opportunity to submit a corrected cost report for the determination described in Sections C.1.a. and C.1.d. of this Chapter. Submittal of a corrected cost report in support of Sections C.1.a. and C.1.d. of this Chapter must be received no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of such corrected cost report for the determination of DSH qualification. Corrected cost reports which are not received in compliance with these time limitations will not be considered for the determination of the hospital's Medicaid inpatient utilization rate as described in Section C.8.e. of this Chapter.

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i. Hospitals' Medicaid inpatient utilization rates, as defined in Section C.8.e. of this Chapter, which have been derived from unaudited cost reports, are not subject to the Review Procedure described in Chapter IX., with the exception of errors in calculation. Pursuant to Section C.3.b. of this Chapter, hospitals shall have the opportunity to submit corrected cost report information prior to the Department's final DSH determination.

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ii. In the event a subsequent final audited cost report reflects a Medicaid inpatient utilization rate, as described in Section C.8.e. of this Chapter, which is lower than the Medicaid inpatient utilization rate derived from the unaudited cost report utilized for the DSH determination, the Department shall recalculate the Medicaid inpatient utilization rate based upon the final audited cost report, and recoup any overpayments made.

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==07/95 c. Certain types of inpatient days of care provided to Title XIX recipients are not available from the cost report, i.e., Medicare/Medicaid crossover claims, out-of-state Title XIX Medicaid utilization levels, Medicaid Health Maintenance Organization (HMO) days, hospital residing long term care days, and Department of Alcohol and Substance Abuse (DASA) Medicaid days. To obtain Medicaid utilization levels in these instances, the Department shall utilize:

==07/95 i. Medicare/Medicaid Crossover Claims. For DSH determination years on or after October 1, 1996, the Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year. Provider logs as described in the remainder of Section C.3.c.i of Chapter VI will not be used in the determination process for DSH determination years on or after October 1, 1996. For DSH determiantion years prior to October 1, 1996, hospitals may submit additional information to document Medicare/Medicaid crossover days that were not billed to the Department due to a determination that the Department had no liability for deductible or coinsurance amounts. That information must be submitted in log form. The log must include a patient account number or medical record number, patient name, Medicaid recipient identification number, Medicare identification number, date of admission, date of discharge, the number of covered days, and the total number of Medicare/Medicaid crossover days. That log must include all Medicare/Medicaid crossover days billed to the Department and all Medicare/Medicaid crossover days which were not billed to the Department for services provided during the hospital's base fiscal year. If a hospital does not submit a log of Medicare/Medicaid crossover days that meets the above requirements, the Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for the hospital's applicable base fiscal year.

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10/92 ii. Out-of-State Title XIX Utilization Levels. Hospital statements and verification reports from other states will be required to verify out-of-state Medicaid recipient utilization levels. The information submitted must include only those days of care provided to out-of-state Medicaid recipients during the hospital's base fiscal year.

10/93 iii. HMO Days. The Department will utilize the Department's HMO claims data available to the Department as of the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of inpatient days provided to recipients enrolled in an HMO.

10/93 iv. Hospital Residing Long Term Care Days. The Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of hospital residing long term care days provided to recipients.

==07/95 v. DASA Days. The Department will utilize the Department's DASA paid claims data available to the Department as of the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of inpatient DASA days provided.

==07/95 4. Hospitals may apply for DSH status under Section C.1.b. of this Chapter, by submitting an audited certified financial statement for the hospital's base fiscal year. The Department of Mental Health and Developmental Disabilities must submit a statement, signed by the Director of that agency, certifying the accuracy of the data submitted for the facilities operated by that agency. The statements must contain the following breakdown of information prior to submittal to the Department for consideration:

10/92 a. Total hospital net revenue for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.

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10/92 b. Total payments received directly from State and local governments for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.

10/93 c. Total gross inpatient hospital charges for charity care (this must not include contractual allowances, bad debt or discounts, except contractual allowances and discounts for Family and Children Assistance, formerly known as General Assistance, and AMI patients), for the hospital's base fiscal year.

10/92 d. Total amount of the hospital's gross charges for inpatient hospital services for the hospital's base fiscal year.

==07/95 5. With the exception of cost-reporting children's hospitals in contiguous states that provide 100 or more inpatient days of care to Illinois program participants, only those cost-reporting hospitals located in states contiguous to Illinois that qualify for DSH in the State in which they are located based upon the Federal definition of a DSH hospital, as defined in Section 1923(b)(1) of the Social Security Act, may qualify for DSH hospital adjustments under Sections C.7.a. and C.7.b. of this Chapter. For purposes of determining the Medicaid inpatient utilization rate, as described in Section C.8.e. and as required in Section 1923(b)(1) of the Social Security Act, out-of-state hospitals will be measured in relationship to one standard deviation above the mean Medicaid inpatient utilization rate in their state. Out-of-state hospitals that do not qualify by the Medicaid inpatient utilization rate from their state may submit an audited certified financial statement as described in Section C.4. Payments to out-of-state hospitals will be allocated using the same methods as described in Section C.7.

10/92 6. Time Limitation Requirements for Additional Information

10/93 a. The information required in Sections C.1.b., C.3., C.4., and C.5., must be received no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of such information for the determination of DSH qualification. Information required in this Chapter which is not received in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.

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10/93 b. The information required in Section C.2. must be received within 30 calendar days of receipt of notification from the Department that the information must be submitted. Information required in this section which is not received in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.

10/92 7. Inpatient Payment Adjustments to DSH Hospitals. The adjustment payments required by Section C.1. of this Chapter shall be calculated annually as follows:

= 03/95 a. Five Million Dollar Fund Adjustment for Hospitals Defined in Chapter XV, Sections A.1. and A.2.

10/93 i. Hospitals qualifying as DSH hospitals under Section C.1.a., that have a Medicaid inpatient utilization rate, as described in Section C.8.e., which is at least one standard deviation above the mean Medicaid inpatient utilization rate, as described in Section C.8.c., and hospitals qualifying as DSH hospitals under Section C.1.b. of this Chapter will receive an add-on payment to their inpatient rate.

10/93 ii. The distribution method for the add-on payment described in Section C.7.a.i. above is based upon a fund of $5 million. All hospitals qualifying under Section C.7.a.i. above will receive a $5 per day add-on to their current rate. The total cost of this adjustment is calculated by multiplying each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) by $5. The total dollar amount of this calculation is then subtracted from the $5 million fund.

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iii. The remaining fund balance is then distributed to the hospitals that qualify under Section C.1.a. of this Chapter that have a Medicaid inpatient utilization rate, as described in Section C.8.e, which is at least one standard deviation above the mean Medicaid inpatient utilization rate, as described in Section C.8.c., in proportion to the percentage by which the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the State's mean Medicaid inpatient utilization rate. This is done by finding the ratio of each hospital's percent Medicaid utilization to the State's mean plus one standard deviation percent Medicaid value. These ratios are then summed and each hospital's proportion of the total is calculated. These proportional values are multiplied by each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization). These weighted values are summed and each hospitals proportion of the summed weighted value is calculated. Each individual hospital's proportional value is then multiplied against the $5 million pool of money available after the $5 per day base add-on has been subtracted.

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iv. The total dollar amount calculated for each qualifying hospital under Section C.7.a.iii., (plus the initial $5 per day add-on amount calculated for each qualifying hospital under Section C.7.a.ii.,) is then divided by the Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) to arrive at per day add-on value. Hospitals qualifying under Section C.1.b. of this Chapter will receive the minimum adjustment of $5 per inpatient day. The adjustments calculated under this subsection are subject to the limitations described in Section C.7.g. of this Chapter.

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10/93 D) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $90 plus $2 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate.

==07/95 iii. For hospitals organized under the University of Illinois Hospital Act, as described in Section A.1.a.ii. of Chapter XVI., the amount calculated pursuant to Section C.7.b.ii. above shall be increased by $60 per day.

==07/95 iv. The Medicaid percentage adjustment payment, calculated in accordance with this Section, to a hospital, other than hospitals organized under the University of Illinois Hospital Act, as described in Section A.1.a.ii. of Chapter XVI., shall not exceed $155 per day for a children's hospital, as described in Section C.1.e. of this Chapter, and shall not exceed $215 per day for all other hospitals.

03/95 v. The amount calculated pursuant to Section C.7.b.ii. through C.7.b.iv. above shall be adjusted on October 1, 1993, and annually thereafter, by a percentage equal to the lesser of:

10/92 A) The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or

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B) The percentage increase in the statewide average hospital payment rate, as described in Section C.8.h. of this Chapter, over the previous year's statewide average hospital payment rate.

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vi. The amount calculated pursuant to Section C.7.a. above for a hospital described in Section A.1.a.i. of Chapter XVI. shall be no less than the DSH rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

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vii. The amount calculated pursuant to Sections C.7.a. and C.7.b.ii. through C.7.b.v. of this Chapter as adjusted pursuant to Sections C.7.d. and C.7.e. shall be the inpatient payment adjustment in dollars for the applicable DSH determination year, subject to the limitations described in Sections C.7.b.iv. and C.7.f. of this Chapter, and the adjustment described in Section C.7.b.vi. above. The adjustments calculated under Sections C.7.a. and C.7.b.ii. through C.7.b.vi. of this Chapter shall be paid on a per diem basis and shall be applied to each covered day of care provided.

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c. DMHDD State-Operated Facility Adjustment for Hospitals defined in Chapter XVI, Section A.7. Department of Mental Health and Developmental Disabilities' (DMHDD) State-operated facilities qualifying under this Chapter, Section C.1.b., shall receive an adjustment effective for inpatient services on or after March 1, 1995. The amount of that payment shall be calculated as follows.

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i. The amount of the adjustment is based on a State DSH Pool. The State DSH pool amount shall be calculated by subtracting the estimated DSH payment adjustments made under Sections C.7.a through C.7.b. of this Chapter, and Chapter XIV, Section F.2. from the aggregate DSH payment adjustment set by the Health Care Financing Administration (HCFA) in accordance with Public Law 102-234.

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03/95 ii. The State DSH Pool amount is then allocated to hospitals defined in Chapter XVI, Section A.7. that qualify for DSH adjustments by multiplying the State DSH Pool amount by each hospital's ratio of Medicaid inpatient utilization (adjusted based upon historical utilization and projected increases in utilization) to the sum of all qualifying hospitals' Medicaid inpatient utilization.

07/95 iii. The adjustment calculated in Section C.7.c.ii. of this Chapter shall meet the limitation described in Section C.7.f.iv. of this Chapter.

==07/95 iv. The adjustment calculated pursuant to Section C.7.c.ii. above, for each hospital defined in Chapter XVI, Section A.7. that qualifies for DSH adjustments, is then divided by the Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) to arrive at a per day adjustment. This amount is subject to the limitations described in Section C.7.f. of this Chapter. The adjustment described in this Chapter shall be paid on a per diem basis and shall be applied to each Medicaid covered day of care provided.

07/95 d. Inpatient Adjustor for Children's Hospitals. For a children's hospital, as defined in Section C.1.e. of this Chapter, the payment adjustment calculated under Section C.7.b. above shall be multiplied by 2.0.

==07/95 e. Inpatient Adjustor for Hospitals Organized Under the University of Illinois Hospital Act. For a hospital organized under the University of Illinois Hospital Act, as defined in Section A.1.a.ii. of Chapter XVI., the payment adjustment calculated under Section C.7.b. above shall be multiplied by 1.50.